

Hackensack
385 Prospect Avenue
Suite 101
Hackensack, NJ, 07601

Marlton
127 Church Road
Suite 203
Marlton, NJ 08053



Long Branch
422 Morris Avenue
Suite 7
Long branch, NJ 07740

Somerset
81 Veronica Avenue
Suite 202
Somerset NJ 08873

OCREVUS ZUNOVO™

(ocrelizumab and hyaluronidase-ocsq)

Date: _____

PATIENT INFORMATION

Name:	Phone:	DOB:	SEX: M ☐ F ☐
☐ NKDA Allergies:		Weight lbs/kg:	

PHYSICIAN INFORMATION

Physician Name:	Practice Name:		
Address:	Office Contact Name:	Office Contact #:	
Phone:	Fax:	Email (for updates):	

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order

OCREVUS ZUNOVO is a CD20-directed cytolytic antibody indicated for the treatment of:

- Relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults (1)
- Primary progressive MS, in adults (1)

- ☐ ICD-10*: _____
☐ Dx Code: _____
☐ Dx Code: _____

PRE-MEDICATION

- ☐ Tylenol PO 650mg ☐ 1000mg ☐ other _____
☐ SoluMedrol 125mg IV ☐ other _____
☐ Benadryl ☐ IVor ☐ PO ☐ 25mg ☐ 50mg ☐ other _____
☐ Dexamethasone ☐ 20mg IV ☐ 20mg ☐ PO ☐ other _____
☐ Desloratadine ☐ 5mg ☐ PO
☐ _____ (other) ☐ _____ (other)

DIAGNOSIS Please provide ICD-10 code

- ☐ G35-MS

WARNINGS AND PRECAUTIONS

https://www.gene.com/download/pdf/ocrevus_zunovo_prescribing.pdf

OCREVUS ZUNOVO ORDERS

PATIENT WEIGHT

_____ lbs.
_____ kg

DOSAGE:

- ☐ Injection 920mg ocrelizumab and 23,000 units of hyaluronidase per 23ml (40 mg and 1,000 units/mL) solution in a single-dose vial

FREQUENCY:

- ☐ Every 6 months for _____ month
☐ Other: _____

LAB DRAW REQUEST

- ☐ Labs: _____
☐ Freq: _____

NOTES/ADDITIONAL COMMENTS:

REQUIRED DOCUMENTATION CHECKLIST:

- ____ Patient Demographics
____ Insurance Card/Information
____ Recent labs to **include Hepatitis Panel and CBC**, as well as
CMP and quantitative, if available
*Please send any other recent labs
____ Recent Progress note and MRI of Brain
____ Other

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Diagnosis Code: _____

Order/dosage: _____

Signature: _____